STATE OF TENNESSEE

DEPARTMENT OF COMMERCE AND INSURANCE

TENNCARE DIVISION

AND

OFFICE OF THE COMPTROLLER OF THE TREASURY

DIVISION OF STATE AUDIT

TENNCARE PARTNERS REPORT

OF

PREMIER BEHAVIORAL SYSTEMS OF TENNESSEE, LLC

NASHVILLE, TENNESSEE

FOR THE PERIOD JULY 1, 1998 THROUGH JUNE 30, 2000

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DATE: October 26, 2001

SUBJECT: Claims Processing and Financial Examination Report of Premier Behavioral Systems of Tennessee, LLC, for the period July 1, 1998 through June 30, 2000

A TennCare Partners Program examination of claims processing and a limited scope financial examination of Premier Behavioral Systems of Tennessee, LLC, 222 Second Avenue North, Suite 220, Nashville, Tennessee, 37201, was completed February 21, 2001. The report of this examination is herein respectfully submitted.

I. FOREWORD

This report reflects the results of a TennCare Partners examination report "by test" of the claims processing system of Premier Behavioral Systems of Tennessee, LLC (Premier). The results of those tests are included herein.

Further, this report reflects the results of the limited scope review of financial statement account balances as reported by Premier.

II. PURPOSE AND SCOPE

A. Authority

The terms and conditions for authorizing the TennCare Partners Program, as well as the contracts between the State of Tennessee and the behavioral health organizations (BHOs), require that examinations of the BHOs be conducted.

This examination was conducted jointly by the TennCare Division of the Tennessee Department of Commerce and Insurance (TDCI) and the Office of the Comptroller of the Treasury, Division of State Audit (Comptroller) under the authorization of Section 3.12.10, 3.13.1, and 3.14.3 of the TennCare Partners contract between the State of Tennessee and the BHOs and Tennessee Code Annotated Sections, 56-51-132 and 56-32-215.

B. Areas Examined and Period Covered

The claims examination focused on the claims processing functions and performance of Premier. One hundred eleven claims were selected for testing from claims processed by Premier from July 1, 1998 through June 30, 2000. The fieldwork was performed from November 2000 through February 21, 2001.

The financial examination focused on the balance sheet and income statement as reported by Premier on its NAIC Quarterly Statement for the periods ended July 1, 1998 through June 30, 2000.

C. Purpose and Objective

The purpose of the claims testing is to determine whether Premier processes claims in accordance with TennCare Partners contract and to determine whether Premier adjudicates such claims timely and accurately.

One objective of the examination is to select for testing, claims processed by Premier to determine if adjudication errors exist and to determine if Premier processed these claims in accordance with the terms of the TennCare contract. These test results are not intended to be representative of the entire claims population of Premier for the aforementioned period.

The purpose of the financial testing is to determine the validity of Premier's assertions that they have complied with certain financial-related requirements of their contract with the state.

The objectives of the financial examination are to determine if amounts reported on the NAIC Quarterly Statements are properly classified and if the amounts reported are properly supported with documentation.

III. PROFILE

A. Overview

The TennCare Partners Program, a managed care capitation program for mental health and substance abuse services, was initiated on July 1, 1996, and is designed to function in a manner similar to the TennCare Program. TennCare replaced the existing Medicaid Program on January 1, 1994, with a program of managed health care providing traditional medical services. Prior to July 1, 1996, mental health and substance abuse services were generally funded by grants or fee-for-service payments from the state. Although some grant payments, such as contracts with the Department of Children's Services, to the community mental health centers are unaffected by the TennCare Partners Program, funding for most of the services has shifted to the TennCare Partners Program. Each month, the state pays a capitation rate for each TennCare Partners Program participant to one of the two managed care organizations, referred to as behavioral health organizations (BHOs), that contract with the state to provide mental health and substance abuse services. The BHOs are Premier Behavioral Systems of Tennessee, LLC, and Tennessee Behavioral Health Inc. (TBH).

The assignment of TennCare Partners Program participants to the two BHOs is based upon the participants' enrollment in the TennCare managed care organizations. There were approximately 722,000 Premier participants as of June 30, 2000. During the

examination period, the managed care organizations and their assigned participants to Premier were as follows:

- Volunteer State Health Plan, Inc.* (excluding East Tennessee**** and Knox County)
- John Deere Health Plan, Inc.**
- Xantus Healthplan of Tennessee, Inc.***
- OmniCare Health Plan, Inc.
- Vanderbilt Health Plans, Inc.

* Doing business as BlueCare.
** Prior to July 1, 1999 the plan was known as Heritage National Healthplan of Tennessee, Inc.
*** Formally Phoenix Healthcare of Tennessee, Inc.
****East Tennessee includes the counties Anderson, Blount, Campbell, Claiborne, Cocke, Grainger, Hamblen, Jefferson, Loudon, Monroe, Morgan, Roane, Scott, Sevier, and Union.

The remaining managed care organizations' enrollments, approximately 595,000, were assigned to TBH.

There are two categories of participants in the TennCare Partners Program: priority participants and basic participants. Priority participants include individuals diagnosed as severely and/or persistently mentally ill (SPMI) aged 18 years or older and individuals under the age of 18 diagnosed as having severe emotional disturbance (SED). TennCare Partners participants who are not priority participants are referred to as basic participants. Services covered for both the priority and basic participants include inpatient psychiatric hospitalization, outpatient mental health services, substance abuse treatment, psychiatric pharmacy and lab-related services, transportation to mental health and substance abuse services, and specialized crisis services. Additional services covered for the priority population includes mental health case management, 24-hour residential treatment, housing/residential care, specialized outpatient and symptom management, and psychiatric rehabilitation services.

An additional category of individuals for which mental health and substance abuse services are covered by the BHOs is judicials. These individuals are not considered enrollees or participants in the BHO plan but are entitled to coverage for services required by the statute or court order under which the individual was referred.

B. Responsibilities of Contracted Parties

The Tennessee Department of Mental Health and Developmental Disabilities [formerly Tennessee Department of Mental Health and Mental Retardation

(TDMHMR)] is the state agency responsible for administration of the TennCare Partners Program. TDMHMR and the Bureau of TennCare are responsible for verifying the eligibility of participants and for assigning them to and disenrolling them from the TennCare Partners Program.

C. Administrative Organization of Premier

Premier Behavioral Systems of Tennessee, LLC, was established in May 1996 for the purpose of delivering mental health services under the TennCare Partners Program. The current members of Premier are Premier Holdings, Inc. (PH), and Columbia Behavioral Health of Tennessee, LLC (CBHT). PH is a wholly owned subsidiary of Advocare of Tennessee, Inc. (Advocare). Advocare is a wholly owned subsidiary of Green Spring Health Services, Inc. (GSHS). GSHS is a wholly owned subsidiary of Magellan Health Services, Inc. CBHT is wholly owned by HCA. Premier contracts with Advocare to provide specific administrative and mental health and substance abuse services through service agreements. Advocare is to provide general administrative services as well as care services for basic and priority outpatient, case management, and grant and crisis payments. Administrative services are paid to Advocare on a per member per month (PMPM) fixed amount. Payments for care services to Advocare are based upon negotiated payments with Community Mental Health Centers (CMHCs) or other providers with no risk assumption by Advocare. Until July 1, 1997, CBHT was to provide care services for inpatient, intensive outpatient, partial hospitalization, and regional mental health institutes. CBHT was paid through June 30, 1997, a PMPM capitation by Premier with risk or benefit depending on whether actual cost of care remains within 3 percent of the actual PMPM amounts paid to CBHT. After June 30, 1997, CBHT provides only the hospital network with no risk assumption for mental health inpatient services and is paid a significantly lower PMPM capitation. Beginning January 1998, Premier contracted with GSHS, to provide claims processing services. As stated above, GSHS is the parent of Advocare.

The officers and board of directors for Premier as of December 31, 1999, were as follows:

Officers for Premier

Charles D. Klusener, President

Bill Hubbard, Esq., Secretary

Board of Directors for Premier

Dennie P. Moody	Kenneth W. Arndt
Paul Rutledge	Eric Ward
Sandy Butters	C. Richard Orndoff

D. Provider Contracts and Subcontracts

The contract between TDMHMR and Premier requires that Premier contract with the State of Tennessee's five regional mental health institutes. These institutes provide essential inpatient mental health services to the priority population. Premier has contracted with the regional mental health institutes on a per diem basis. Inpatient, intensive outpatient, and partial hospitalization services are also provided by hospitals across Tennessee on a per diem basis.

In addition, the contract encourages Premier to contract with community mental health centers (CMHCs). The primary providers of outpatient mental health services for the priority population are the CMHCs located across the state. Premier originally contracted with 29 CMHCs to provide medically/psychologically necessary designated covered services. The CMHCs act as care coordinators responsible for arranging the behavioral health care needs of their assigned participants. Initially, all of the centers except three had a contractual arrangement with Premier which specified a certain per priority member per month rate to be used in the calculation of the monthly priority case rate paid to those centers. Premier calculated the monthly case rate for each of these centers by multiplying the number of priority participants reported by a center by the specified per member per month rate, then dividing that number by the total priority cases reported for all centers. The other three centers' contractual arrangements specified a fixed case rate. The assignment of the priority population to the CMHCs at the effective date of the contracts, July 1, 1996, was based on a comparison between the CMHC's enrollment records with MCO or BHO enrollment data. Assignment of newly assigned priority members was determined by member's choice. If the assigned members elected to receive services from other providers, then the CMHC's monthly case rate payments were reduced on a percentage basis according to the services received.

On March 1, 2000, most CMHCs amended their contract with Premier to be reimbursed through a new compensation method. Instead of payments based being based on the number of priority members assigned to the CMHC, the new compensation method reimburses the CMHC in tiered levels based on the average number of case management encounters per priority participants.

Each CMHC also receives grant payments at the same funding levels for the prior fiscal year based on Premier's percentage of total TennCare Partners enrollment. Grants represent payments for non-clinical adult services, psychosocial services, and crisis teams provided by the CMHCs.

Other providers include physicians, psychiatrists, licensed social workers, and hospitals and are paid based upon a fee schedule or per diem for the procedures or inpatient days provided.

Five TennCare managed care organizations (MCOs) have been contracted and paid by Premier a subcapitation based upon number of members enrolled in the MCOs. The MCOs have contracted with primary care physicians who provide a portion of the mental health services for Premier. Also, the MCOs provide some of the lab, transportation, and pharmacy services that are the responsibility of Premier.

Effective July 1, 1998, the State assumed financial responsibility for the cost of all behavioral health pharmacy services to TennCare enrollees in the TennCare Partners Program.

IV. PREVIOUS EXAMINATION FINDINGS

The following were deficiencies cited in the examination by the Comptroller of the Treasury, Division of State Audit, for the period January 1, 1997, through June 30, 1998.

1. **Deficiencies in the Claims Processing**
   Premier did not fulfill contract reporting requirements and processing efficiency requirements specified by the TennCare Partners contract. Errors were discovered in the payment and denial of mental health and substance abuse claims.

2. **Deficiencies in the Authorization System**
   Premier has invalidity denied claims for no prior authorization when a valid authorization exists. Premier's authorization system failed to properly transfer all authorizations to the claims processing subcontractor in a timely manner.

3. **Deficiencies in Encounter Data Reporting**
   Premier inadequately reported encounter data required by the contract: the encounter data did not include all revenue, procedure, and diagnosis codes.

4. **Inaccurate Annual and Quarterly Statement Reporting**
   Equity was understated $1,520,677 as of December 31, 1997, and overstated $6,656 as of June 30, 1998 due to errors in the annual statement reporting.

5. **Incomplete Payment Calculations to Community Mental Health Centers**
   Premier did not apply all of the compensation terms of their contracts with CMHCs.

6. **Provider Contract Language Deficiencies**
   Premier did not include in the provider agreements all requirements specified by the TennCare Partners contract.

   Finding 5 has been satisfactorily remedied. Findings 1, 2, 3, 4, and 6 will be repeated in the current report.

V. SUMMARY OF PERTINENT FACTUAL FINDINGS

A. Summary of Deficiencies – Financial

1. Premier did not provide the examiners with requested information, specifically the general ledgers of an affiliate, which support the allocation of administrative expenses on the NAIC Financial Statements.

2. Premier understated IBNR at June 30, 2000. TDCI non-admitted unsupported health care receivables. Both items resulted in Premier's June 30, 2000, net worth being overstated and adjusted by TDCI.

B. Summary of Deficiencies – Claims Processing System

1. Premier incorrectly paid nine (9) of sixty (60) claims reviewed.

2. Premier improperly denied three (3) of sixty (60) claims reviewed.

3. Premier inadequately reported encounter data required by the TennCare Partners contract. The encounter data did not include all revenue, procedure, and diagnosis codes.

4. Of fifty-one (51) Regional Mental Health Institute claims reviewed, Premier incorrectly paid fifteen (15) claims.

5. Of fifty-one (51) Regional Mental Health Institute claims reviewed, Premier improperly denied twenty-nine (29) claims.

6. Premier is not in compliance with Tennessee Code Annotated (T.C.A.) § 56-32-226(b) requirements for timely adjudication of claims.

C. Summary of Other Deficiency

Premier did not include in the provider agreements all the requirements specified by Section 3.9.2 of the TennCare Partners contract.

VI. RESULTS OF TESTS CONDUCTED – FINANCIAL ANALYSIS

A. Financial Analysis

As a BHO, Premier files annual and quarterly statements with the Tennessee Department of Commerce and Insurance. The department uses the information filed on these reports to determine if the behavioral health organization meets the minimum requirements for statutory reserves. The statements are filed on a statutory basis of accounting. Statutory

accounting differs from generally accepted accounting principles because "admitted" assets must be easily converted to cash to pay for outstanding claims. "Non-admitted" assets such as furniture, equipment, and prepaid expenses are not to be included in the determination of plan assets and should be reduced from equity.

As of December 31, 1998, Premier reported $41,463,692 in admitted assets, $21,362,916 in liabilities and $20,100,776 in equity on its annual statement. Premier reported total revenues of $185,643,975 and total expenses of $170,742,358, producing a net income of $14,901,617 for the period January 1 through December 31, 1998. Revenue is composed of $183,986,747 in capitation payments from the TennCare Partners Program and $1,657,228 in investment income. The plan reported $150,472,869 in mental health and substance abuse services and $20,269,489 in administrative expenses. Premium taxes paid to the State were reported as $3,304,842. Mental health and substance abuse services represent 81% of capitation payments from TennCare, and administrative expenses less premium taxes represent 11.0% of capitation payments from TennCare. Premier reported a restricted deposit of $2,200,000 to satisfy requirements of the TennCare Partners Program contract.

As of December 31, 1999, Premier reported $40,805,187 in admitted assets, $20,083,479 in liabilities and $20,721,708 in equity on its annual statement. Premier reported total revenues of $183,228,270 and total expenses of $179,161,649 producing a net income of $4,066,621 for the period January 1 through December 31, 1999. Revenue is composed of $180,983,281 in capitation payments from the TennCare Partners Program and $2,244,989 in investment income. The plan reported $156,865,316 in mental health and substance abuse services and $22,296,333 in administrative expenses. Premium taxes paid to the State were reported as $3,180,092. Mental health and substance abuse services represents 86.7 % of capitation payments from TennCare, and administrative expenses less premium taxes represents 12.3 % of capitation payments from TennCare. Premier reported a restricted deposit of $3,200,000 to satisfy requirements of the TennCare Partners Program contract and an increased requirement imposed by TDCI for failure to provide required financial information.

As of June 30, 2000, Premier reported $44,762,837 in admitted assets, $23,501,836 in liabilities, and $21,261,001 in equity on its quarterly statement. Premier reported total revenues of $91,067,987 and total expenses of $92,052,702 producing a net income/(loss) of ($984,715) for the period January 1 through June 30, 2000. Revenue is composed of $89,844,605 in capitation payments from the TennCare Partners Program and $1,223,382 in investment income. The plan reported $79,689,023 in mental health and substance abuse services and $12,363,679 in administrative expenses. Premium taxes paid to the State were reported as $1,583,705. Mental health and substance abuse services represents 88.7 % of capitation payments from TennCare and administrative expenses less premium taxes represents 13.8 % of capitation payments from TennCare. Premier reported a restricted deposit of $3,200,000 to satisfy requirements of the

TennCare Partners Program contract and an increased requirement imposed by TDCI for failure to provide required financial information.

During the examination, examiners reviewed account balances on the NAIC Quarterly Statement to determine if they were properly supported. Examiners also reviewed subsequent events to determine if significant changes in accounting estimates were necessary.

The TennCare Partners contract imposes certain financial requirements on the BHOs regarding minimum net worth, working capital and restricted deposits.

1. Net Worth

As of June 30, 2000, the TennCare Partners contract required Premier to establish and maintain a minimum net worth equal to the greater of (1) three million dollars ($3,000,000), or (2) an amount totaling five percent (5%) of the first one hundred fifty million dollars ($150,000,000) of the TennCare revenue earned by Premier under the TennCare Partners contract for the prior calendar year, plus three percent (3%) of the TennCare revenue earned by the Premier under the TennCare Partners contract in excess of one hundred fifty million dollars ($150,000,000) for the prior calendar year. This net worth was to be determined by statutory accounting principles utilized by TDCI in regulating HMOs licensed in the State of Tennessee. Based on this minimum net worth calculation, Premier was required to maintain a minimum net worth of $8,429,498 during the calendar year 2000 ($180,983,281 TennCare revenue calendar year 1999 - $150,000,000 times 5% plus $30,983,281 times 3%). However, effective July 1, 2000, the Contract was amended to implement a change in the net worth requirement based upon the statutory requirements set out in TCA 56-51-136. The new requirement is the same as for TennCare Health Maintenance Organizations or 4% of the first $150,000,000 in TennCare premium revenue on the most recent annual statement filed plus 1.5% of the annual premium revenue in excess of $150,000,000.

Premier determined subsequent to the filing of its NAIC financial statements for the quarter ended June 30, 2000, and subsequent to TDCI's fieldwork for this examination also for the period then ended, that IBNR as of June 30, 2000, was understated by $10,853,252. As a result of the IBNR understatement, Premier's reported June 30, 2000, net worth was overstated by this same amount.

Premier contends that during 2000, it was determined, based on a detail review of claims payments, that there were claims that had been paid inappropriately to providers. The reasons for the payments being inappropriate varied (i.e. non-covered services, contract non-compliance, claims not filed in a timely manner, etc.) While the BHOs worked on recovering the money, a receivable of $863,846 was booked by BHO. TDCI requested support for the receivable and none was

provided. That receivable has been determined unsupported and will be adjusted from net worth.

Premier reported net worth at June 30, 2000, of $21,261,001; net worth adjusted for the unsupported health care receivable of $863,846 and understated IBNR of $10,853,252 resulted in a reduction to net worth of $11,717,098 for an adjusted net worth of $9,543,903. Premier's minimum net worth requirement calculated under the TennCare Partners Contract at June 30, 2000 is $8,429,498. Premier's adjusted net worth is $9,543,903, for a statutory net worth surplus of $1,114,405 at June 30, 2000.

TDCI is aware of the fact that there is currently a payment dispute between Premier and TDMHMR regarding payments to the Regional Mental Health Institutes. To date TDCI has not received requests for independent review from TDMHMR for the disputed claims. If the potential liability comes to pass, Premier could be in a negative net worth position at June 30, 2000, depending on settlement amounts. TDCI will continue to closely monitor the progress of the dispute resolution.

2. Working Capital

Premier must establish and maintain a positive working capital defined as current assets greater than current liabilities per Section 3.3.2.2 of the TennCare Partners contract. Premier's current assets did exceed current liabilities at June 30, 2000.

3. Restricted Deposit

The TennCare Partners contract Section 3.3.2.3 requires Premier to maintain a restricted deposit of $600,000 plus an additional $200,000 for each $20,000,000 or fraction thereof of the TennCare revenue earned by the BHO in excess of $40,000,000 as reported on the most recent annual statement filed with TDCI. Premier's contractual deposit requirement at June 30, 2000 was $2,200,000 however; TDCI required Premier to increase its deposit by $1,000,000 for failure to timely submit its 1998 independent audit report as required by the TennCare Partners contract. Premier had funds with a par value of $3,320,000 in restricted deposits at June 30, 2000 to satisfy the deposit requirements.

4. Contractor's Management Fee

The BHO is allowed to retain ten percent (10%) of the capitation payment for administrative and management fees and profits with the remaining being made available for providing or arranging direct mental health and substance abuse services to TennCare enrollees. No later than July 15 of each calendar year, the BHO must calculate the total amount of expense for covered services incurred during the preceding calendar year, as well as any premium taxes paid by the BHO to the state.

> If the actual accrued amount paid by the BHO for covered services and premium taxes is less than the required amount paid the BHO by the state for the preceding year, the BHO must remit to TDMHMR one hundred percent of the difference. However, the amount to be remitted by the BHO shall be reduced by any cumulative losses incurred by the BHO from the participation in the TennCare Partner's Program in prior years. Note: Amendment 3 to the Partner's contract effective July 1, 2000, no longer allows for a cumulative loss carry forward.
>
> As of December 31, 1999, Premier's cumulative losses based on the above calculation totaled $5,141,866.

B. <u>Allocation of Administration Expense</u>

As previously discussed, AdvoCare, a related party, contracts with Premier to manage the operations, administrative services and clinical services related to provision of all mental health benefits, to provide case management services and to arrange primary care and outpatient services. Premier did not provide the examiners with requested information, specifically the general ledgers of its affiliate, which support the allocation of administrative expenses on the NAIC Financial Statements. Premier's failure to provide the requested information is a violation of the following TennCare Partners Contract terms and Tennessee Code Annotated statutes:

Section 3.14.2 of the TennCare Partners contract between the plan and the state specifies:

> The CONTRACTOR shall maintain books, records, documents, and other evidence pertaining to the administrative costs and expenses incurred under this CONTRACT… These records, books, documents, etc., shall be available for review by authorized federal, State, and Comptroller personnel…

Also, Section 3.14.3 of the TennCare Partners contract specifies:

> The CONTRACTOR shall make available to the Tennessee Department of Mental Health and Mental Retardation or its representatives and other state and federal personnel…all records, books, documents, and other evidence pertaining to this CONTRACT, as well as appropriate administrative and /or management personnel who administer the plan.

T.C.A. § 56-51-154, Applicability of provision of title 56, chapter 32 to successor organizations, states:

> Provisions of title 56, chapter 32 which are specifically applicable to health maintenance organizations which participate in the TennCare Program under the Social Security Act, title XIX, or any successor to the TennCare program shall also

be applicable to prepaid limited health service organizations which participate in the TennCare program or any successor program.

T.C.A. § 56-32-232, Investigatory powers of the department of commerce and insurance, states:

For the purpose of regulation and oversight of health maintenance organizations that participate in the TennCare program under the Social Security Act, Title XIX, or any successor to the TennCare program, and in addition to the powers and duties set forth in this title, the department of commerce and insurance has the power to examine and investigate the affairs of every person, entity, health maintenance organization, an affiliate of the parent of the health maintenance organization, or an affiliate of the health maintenance organization, in order to determine whether the person, entity, health maintenance organization, an affiliate of the parent of the health maintenance organization, or any affiliate of the health maintenance organization, is operating in accordance with the provisions of this part and title 71, chapter 5.

Management's Comments:

Management did not respond.

VII. RESULTS OF TESTS CONDUCTED – CLAIMS PROCESSING SYSTEM

A. Sixty (60) claims were judgmentally selected from a file containing the claims history of two hundred (200) Premier members. The claims reviewed were for services provided from July 1, 1998 through June 30, 2000. Of the sixty (60) claims tested, thirty-two (32) were paid and twenty-eight (28) were denied.

1. Adjudication Accuracy

The purpose of adjudication accuracy testing is to determine whether the decision to reject, deny or pay a claim was appropriate based on available information including but not limited to eligibility status, claim submission date, date of services and denial reasons.

a. Paid Claims

Twenty-three (23) of the thirty-two (32) paid claims tested were correctly paid and nine (9) were incorrectly paid. *Three (3) of these claims were initially paid incorrectly but were later reprocessed and correctly paid.* The errors noted in nine (9) incorrectly paid claims are listed below:

- Three (3) claims paid the mental health and substance abuse provider twice for the same service. Two (2) of the claims were from CMHC providers and

were paid both a monthly case rate and fee-for-service rate. (20000053373, 990403199) One (1) claim was paid twice to a transportation provider. (20000243826) These overpayments have yet to be reconciled by Premier.

- Five (5) claims incorrectly applied a ten percent (10%) withhold. Three (3) of these were CMHC claims. (980166531, 980089479, 980096471) *Two (2) of the claims were for transportation services and both of these were later reprocessed and the ten percent (10%) withhold was returned to the providers.* (20000243826, 20000202818)

- The payment for one (1) claim did not agree with the provider's fee schedule. *Premier has correctly reprocessed and paid the claim.* (990413703)

Management's Comments:

Management did not respond.

b. Denied Claims

Twenty-five (25) of the twenty-eight (28) denied claims were appropriately denied and three (3) were improperly denied. *Two (2) of the improperly denied claims were later reprocessed and paid.* The errors noted in the three (3) improperly denied claims are listed below:

- One (1) claim denied for procedure code not authorized. One (1) of the lines had been authorized and should have been paid. *Premier has reprocessed and paid the claim.* (990071438)

- One (1) claim was denied for timely filing even though the date stamp indicated the claim was initially filed in 119 days, which is considered timely. (990249874)

- One (1) claim was denied because no explanation of benefits (EOB) was attached to the claim from the enrollee's other insurance. No other insurance was indicated on the claim. The enrollee's other insurance had expired before the date of service on the claim. *Premier has reprocessed and paid the claim.* (2000346453)

Management's Comments:

Management did not respond.

2. Price Accuracy Testing

   The purpose of price accuracy testing is to determine whether payments allowed for specific procedures are in accordance with the system price rules assigned to providers, whether payments are in accordance with provider contracts, and whether amounts were calculated correctly.

   All thirty-two (32) paid claims were tested and thirty-one (31) were priced accurately according to the executed provider contracts. One (1) claim was incorrectly priced. (990413703)

   Management's Comments:

   Management did not respond.

3. Remittance Advice Testing

   Remittance advices are used to communicate to the providers relevant information regarding the payment or denial of their claims. Remittance advices were requested for five (5) of the sixty (60) tested claims to compare the payment and/or denial reasons per the claims processing system to the information communicated to the providers.

   No differences were noted between the claims payment and/or denial information per the claims processing system and the related information communicated to the providers of the five (5) remittance advices reviewed.

4. Electronic Claims Capability

   During the examination period, Premier had the ability to receive and process claims electronically filed by transportation providers and community mental health centers. Of the sixty (60) claims tested, six (6) were filed electronically.

   Management's Comments:

   Management did not respond.

5. Comparison of Actual Claim With System Claim

   Original hard copy claims were requested for the fifty-four (54) claims of the sixty (60) tested that were not filed electronically by the providers. (Refer to Section VII.A.4. above.) The information reported on the hard copy claims was compared to the claims information entered into the claims processing system. Of the fifty-four (54) claims reviewed, seventeen (17), contained data elements that did not

match the data elements entered into the claims processing system. Of the seventeen (17) claims with discrepancies, nine (9) claims are mentioned in more than one category resulting in a total of twenty-nine (29) discrepancies noted below:

- For ten (10) claims, a substitute code was incorrectly reported for the medical diagnosis codes indicated on the claims. (990404376, 20000082699, 990233292, 990443109, 980251324, 990049954, 990331887, 20000091569, 20000067929, 990358264)

- For four (4) claims, the reported revenue code per the claim was not the same as the revenue code entered into the claims processing system. (990233292, 990443109, 990049954, 990358264)

- For fifteen (15) claims, all listed diagnosis codes were not reported as encounter codes. (20000232612, 990404376, 980232065, 20000082699, 990233292, 990080901, 20000216836, 990100495, 990443109, 980251324, 20000091569, 20000067929, 990358264, 20000458412, 20000463785)

Management's Comments:

Management did not respond.

B. Fifty-one (51) Regional Mental Health Institute (RMHI) claims for services provided from July 1, 1998 through August 17, 2000 were reviewed. The claims were selected for review based on a complaint that they were processed incorrectly. Of the RMHI claims tested, twenty-one (21) were paid and thirty (30) were denied. The results of the claims testing are summarized below:

1. Paid Claims

Fifteen (15) of the twenty-one (21) paid claims were paid incorrectly. *Two (2) of these claims were initially paid incorrectly but were later reprocessed and correctly paid.* Of the fifteen (15) incorrectly paid claims, one (1) of the claims is mentioned in more than one category resulting in a total of sixteen (16) deficiencies listed below:

- Seven (7) claims did not pay in agreement with the negotiated rate. (990032296, 20000452154, 20000277608, 20000277606, 20000277540, 20000277735, 20000435580)

- Seven (7) claims did not pay all of the inpatient days that were pre-authorized per the authorization letters sent to the RMHIs. *Two (2) of the claims were later reprocessed and the remaining authorized days were paid.* (990288539,

990029952, 990032296, 990119053, 20000277668, 20000132986, 20000555855)

- Two (2) claims paid all but the first day of service, which was denied for no coverage in effect for the enrollee. Both of these enrollees had coverage beginning on the first date of service. These claims were continued stays and therefore both the admission date and the last day on the interim billing should have been paid. (9802121609, 990045437)

Management's Comments:

Management did not respond.

2. Denied Claims

One (1) of the thirty (30) denied claims was appropriately denied and twenty-nine (29) were improperly denied. *Nine (9) of the improperly denied claims were later reprocessed and paid.* Of the twenty-nine (29) improperly denied claims, six (6) claims are mentioned in more than one category resulting in a total of thirty-five (35) deficiencies listed below:

- Nine (9) claims denied for no coverage in effect for the enrollee. In eight (8) of these cases the enrollee had coverage from the initial date of service and throughout the stay but the entire claim was denied. *One (1) of the claims was later reprocessed and paid.* (990345761, 980251956, 990170809, 980278252, 990003959, 20000502593, 20000504516, 20000559713) For one claim the enrollee's coverage did not begin until the last few dates of service but the entire claim was denied for no coverage in effect. (990137093)

- Fourteen (14) claims denied for "no pre-authorization on file" and/or "dates of service beyond the authorization period". In each instance a pre-authorization from AdvoCare was issued to the RMHI. *Seven (7) of the claims were later reprocessed and paid.* (990077687, 990045236, 990234286, 990289333, 990354242, 990065108, 990029386, 990029230, 990012880, 990174534, 990281074, 20000491037, 20000277441, 20000370800)

- One (1) claim denied for "services billed do not match the authorization". However, the pre-authorization letter and the authorization in Premier's authorization system did match the services billed on the claim. (20000106599)

- Three (3) claims denied for no pre-authorization on file. Each of these enrollees were presumptively assigned to Tennessee Behavioral Health (TBH) and the pre-authorization was issued by AdvoCare for TBH. The enrollee was later assigned to Premier and the claim was sent to Premier. The authorizations for these three

(3) claims were never moved to Premier in order to properly process and pay these claims. (20000554574, 20000452110, 20000491037)

- Six (6) claims denied for no pre-authorization were for a court-ordered emergency admission. Premier is required to pay at least the first 72 hours on a court-ordered emergency admission without a requirement for an authorization per Section 2.6.5.1.1.1 of the TennCare Partners contract. *One (1) of these claims was later reprocessed and paid.* (990029386, 990281074, 20000554561, 20000554574, 20000452110, 20000277441)

- One (1) claim denied without a denial code or explanation communicated to the provider on the provider remittance advice. The RMHI had obtained a pre-authorization letter from Premier. This was also a court-ordered emergency admission. (990121565)

- One (1) claim denied for no Medicare EOB attached. This was a Medicare dual-eligible enrollee. However, the claim was correctly submitted for payment showing that the Medicare benefits had been exhausted and the days were non-covered Medicare days. Per Premier, this information is sufficient for paying the claim. This claim also pertained to a court-ordered emergency admission. (20000435512)

Management's Comments:

Management did not respond.

C. Results of Prompt Pay Analysis

As part of our on-going analysis of the BHOs, TDCI requests on a quarterly basis a data file from the BHO containing all claims processed for a selected month. The data file is used to determine the BHO's compliance with the processing requirements defined in T.C.A. §§ 56-32-226(b) and 71-5-2314 which require that each BHO (as an entity contracting with the state in the TennCare Partners Program) shall ensure that 90% of claims for payments of services delivered to a TennCare Partners Program enrollee are paid within 30 days of the receipt of such claims and shall process, and if appropriate pay, within 60 days 99.5% of all provider claims. Process means the BHO must send the provider a written remittance advice or other appropriate written notice evidencing that the claim has been partially or totally denied and specify all known reasons for denial.

Results of the Analysis of the January 2001 Data File

Claim Type	Within 30 days	Within 60 days	Greater than 60 days
Fee For Service Claims Only	69.9%	99.4%	.6%
Fee For Service and CMHC Claims	82.3%	99.7%	.3%

The results are presented in both formats because of the unique contracting arrangement with the CMHCs. The BHO makes interim payments for the current month claims based on a reconciliation of claims submitted for dates of service six months in the past. CMHC claims submitted on the data file have been considered paid within 30 days for this analysis.

In January 2001, Premier is not compliance with T.C.A. §§ 56-32-226(b) and 71-5-2314 requirements that 90% of claims are paid with 30 days of receipt. Premier was in compliance with §§ 56-32-226(b) and 71-5-2314 requirements to process within 60 day 99.5% of all provider claims only if CMHC claims are also considered in the analysis.

Results of the Analysis of the April 2001 Data File

Claim Type	Within 30 days	Within 60 days	Greater than 60 days
Fee For Service Claims Only	84.04%	99.21%	.79%
Fee For Service and CMHC Claims	92.84%	99.65%	.35%

The same assumptions apply to the April analysis for CMHC payments that applied to the January analysis.

Based on the April data file analysis, and if CMHC capitated claims are considered processed within 30 days, Premier does meet the prompt pay requirements of T.C.A. § 56-32-226(b).

Management's Comments:

Management did not respond.

VIII. REPORT OF OTHER FINDINGS AND ANALYSES

A. Provider Contract Language Deficiencies

Premier did not comply with the Bureau of TennCare's requirements for provider agreements. The provider agreements did not contain all requirements specified in Section 3.9.2 of the TennCare Partners contract.

Four executed provider agreements were requested for compliance analysis; one CMHC agreement, one primary care physician (PCP) agreement, one hospital agreement and one transportation agreement. Of the four requested only three were provided. See item B. below.

Language describing the following requirements is excluded or deficient from the PCP contract:

Section 3.9.2.20. Provide the name and address of the official payee to whom payment shall be made.

Section 3.9.2.44. No agreement executed between the CONTRACTOR and a provider shall require the provider to assume financial risk for the provision of services which are not directly or indirectly furnished by that provider to a participant in the TennCare Partners Program. The term indirectly means that the provider retains ultimate management and control over the services furnished to participants in the TennCare Partners Program. The CONTRACTOR may request the TennCare Division of TDCI to provide, in advance, a written opinion whether a proposed contract provision is in compliance with this section, and the TennCare Division of TDCI must respond to any such request within thirty (30) calendar days after receipt of the request by the TennCare Division of TDCI. TDMHMR, in addition to any and all remedies set forth in the CONTRACT, may also commence an action against the CONTRACTOR in accordance with Section 6.11 of the CONTRACT to recover from the CONTRACTOR any losses incurred by a provider as a result of the CONTRACTOR's breach of this section. Any amounts recovered by TDMHMR which are for losses incurred by a provider as a result of the CONTRATOR's breach of this section shall be returned without interest to the provider.

Management's Comments:

Management did not respond.

B. Transportation Contracts

One of the four contracts requested from Premier for testing was a transportation contract. Premier provided a memorandum of agreement with their transportation provider that was conditional until the parties execute a contract. None of the transportation provider contracts were executed at the time of our review. (Note: telephone follow-up indicated that currently the majority of the transportation contracts have been executed.)

Management's Comments:
Management did not respond.

The examiners hereby acknowledge the courtesy and cooperation of the officers and employees of Premier.